BOROUGH of CHARD

Annual Report

OF THE

Medical Officer of Health

for the Year ended 31st December, 1956

PUBLIC HEALTH OFFICERS:

Medical Officer of Health:
A. M. McCALL, M.R.C.S., L.R.C.P., D.P.H.

Deputy Medical Officer of Health:
P. P. FOX, M.B., Ch.B., D.P.H.

Public Health Inspector:
P. H. WEBB, M.I.M. & C.E.

PUBLIC HEALTH COMMITTEE.

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M. H. Collins
Mrs. Bryer
L. Fisher
J. E. Case
R. W. Long
W. A. H. Evans
D. C. Golesworthy

HOUSING COMMITTEE.

L. Fisher (Chairman)
R. W. Long
Mrs. Bryer
E. T. Phelps
S. C. Major
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G. E. Slocombe, S.R.N., S.C.M., H.V.
J. D. Ralston, S.R.N., S.C.M., H.V.
H. E. Parker, S.R.N., S.C.M., H.V.
O. J. M. Pitt, S.R.N., S.C.M., H.V.

YOUNG AND SON (PRINTERS), LTD., CHARD

Annual Report of the MEDICAL OFFICER OF HEALTH

To the Mayor, Aldermen and Councillors of the Borough of Chard.

Mr. Mayor and Councillors,

I beg to submit my Annual Report for the year 1956.

It was a healthy year with few infectious diseases notified. There was a small outbreak of food poisoning which I thought interesting enough to report in some detail.

One new clinic was started during the year, otherwise the services remained the same. Unfortunately the school dental surgeon who was working in the area resigned at the beginning of the year and I have discussed the problem at length. It is particularly regrettable that, although occasional dental treatment has been available through the County Service for schoolchildren, so far no treatment has been provided for expectant and nursing mothers.

It is a Statutory requirement for the Medical Officer of Health to produce an Annual Report for his area. The headings under which he reports are laid down and vary little from year to year. In an effort to avoid my reports becoming dull and uninteresting, I try to increase their value by discussing current problems in the field of preventive medicine and I hope the notes I have included on the causes of death, the Rh. factor, spastics, etc., will stimulate an interest in this year's report.

I wish to acknowledge the courtesy shown to me by the Public Health Committee and the Council during the year.

I am, Mr. Mayor and Councillors,

Your obedient Servant,

A. M. McCALL,

Medical Officer of Health.

SECTION A.

Statistics and Social Conditions of the Area

Chard is the most southerly town in Somerset. It was known to the Romans and was called Cerdre in the Domesday Book. The name is derived from a Saxon named Cerdic who came in 495 and subseqently became King of Wessex in 519.

The town previously consisted of Old Town until Bishop Jocelyn gave 52 acres out of the Manor of Chard to enlarge the town. Originally it had the privilege of sending a Member to Parliament, but it was of short duration (1300—1329). The burgesses quarrelled among themselves, objected to the expense of a paid member and soon forfeited by disuse the privilege which was never restored.

Chard has always been a centre of trade and was noted for its weekly market. In 1790 the potato market was the largest in the West of England.

At one time the manufacture of cloth was the staple trade. This was superseded by lace, a trade which still survives. Now, of course, light engineering is the main source of employment.

In 1854 the population was 2,291. The Registrar General gives the population for 1956 as 5,390. The general statistical details of the town are given in Appendix A, Table 1.

Birth Rate.

The Birth Rate for the year was 14.5 per thousand, which is an increase on the previous year's figure of 12.9 but is below the national figure of 15.7, which is the highest since 1950.

Death Rate.

The Death Rate for the year was 10.9 per thousand, about the same as the previous year (10.7). When the comparability factor is taken into account our figure of 9.95 per thousand compares favourably with the national figure of 11.7. The causes of death are shown in Appendix A, Table 2.

Diseases of the heart and circulation were the greatest killers, having caused over half the total deaths, 31 out of a total of 59. Although second, cancer caused only 6 deaths, two of which were cancer of the lung.

Longevity, which means length of life, is a subject which has always held a great deal of fascination for the man who is impressed by long life in others and usually wants to achieve it himself. There are quite a few of these.

It is fair to say that the age at which one dies depends on how long one succeeds in avoiding death by accident or disease. Since we all die after a maximum of, perhaps, a hundred and ten years, there must be a point beyond which no one can continue to escape the multifarious causes of death which compete for him. The Registrar General recognises a large number of distinct causes of death of which senility is only one and the question arises whether it is possible to die of old age as such. Has an individual a maximum capacity which limits his life so that he must die of a general wearing out of his tissues at an advanced age? The vast majority of human beings die of specific and identifiable failures of structure or function and in a given year very few deaths have to be attributed to senility and other ill defined causes.

Nevertheless, it could be argued that virtually all deaths other than those caused by accident or infection are in fact deaths of old age though not specified as such. These include deaths from degeneration of the heart and arteries and vescular lesions of the nervous system. In addition the age incidence of deaths from cancer allows a case to be made for it as a disease of ageing tissues, as it is essentially due to loss of control over what should be the normal replacement of tissue.

Man's life seems to be limited to an average of something over 70 years, by which time most people succumb to failure of one system or another. Since a system which fails in one man at 70 may work well in another until something else kills him at 90 or in a third may fail at 45, there is reason to hope that simply by care and forethought man's average lifespan may be prolonged to come a little nearer the apparent maximum of 110.

Every year in England and Wales about half a million people die. If longevity is their aim, then some fall very early by the wayside. Losses are light in the age groups of childhood and youth but from the age of 45 or so onwards casualties are very heavy and very few survive to do better than average in the 80s and 90s.

The first year of life is an immediate problem and danger. Then follows a period of comparative safety. Once 45 is reached men survive far worse than women. At 75 far more males die than females. The remarkable thing is not that so many women die at ages above 75, but that so many women survive to such advanced ages in this country when their male counterparts die between 45 and 75 in far higher proportion. It is well known that widows far outnumber widowers in England.

It is obvious that in considering the length of life of the ordinary man and the factors affecting it, we must look carefully at the causes of death involved.

Individual tissues have no specific time limit. Most people succumb to a failure, slow or sudden, of a particular system of the body. This may be fatal in itself, or fatal only because of the general senility of the body as a whole. The cardio-vascular system is the one which gives way most often. The general changes which occur with ageing are partly known. The first effect of this is a loss of elasticity in the arterial walls. Most of the deaths due to this are caused by blood clotting in the constricted artery as in coronary thrombosis, where part of the heart muscle is deprived of its blood supply. A large number of deaths are due to the actual rupture of the artery as in cerebral haemorrhage. A non-fatal haemorrhage leads to the familiar stroke with varying degree of paralysis. There is a good deal of truth in the cliche that a man is as old as his arteries.

Some obvious changes which occur with ageing are deterioration in the functioning of the organs of special sense. In the eye, accommodation is slowly lost and the nearest clearly visible point recedes—the familiar figure of the ageing person holding the paper at arms length. There is a decreasing range of hearing as age increases, particularly in the higher frequencies. Cerebral development, distinct from development of character and intellect, ceases in youth and the ability to learn decreases slowly, but is masked by the accuracy and wisdom which come with the accumulation of experience. On the whole, normal degeneration of the central nervous system does not affect the length of life though it affects the tempo at which it is lived. Although indigestion is common in older people, the digestive apparatus is very durable and can outlast the rest of

the body in most cases. Renal function tends to become less efficient in old age.

Muscle power is usually retained at very nearly the youthful maximum until about 40. It drops slightly then and the drop becomes sharp in the 60s. The individual variations in the age and extent to which these changes occur are very great indeed, and many 40 year old men are genuinely senile while others in their 70s are well preserved and fairly youthful.

The individual glands have great durability and the system as a whole should easily last a century or more.. Few people fail to reach old age because of a failure of the glandular system as such, but it is certainly linked with other systems which breakdown in old age. It may be that some overbalance of the glandular system can lead to a rapid failure of another system.

The respiratory system does not change greatly in old age except in its ability to resist and recover from infection. The lungs, unless subjected over a period of years to silica or coal dust, could outlast most of the rest of the body by many years if it were not for infection. Bronchitis and influenza mainly in old people cause a number of deaths and a failure of the respiratory system to resist infection. So an important factor determining the length of life is the definite lowering of resistance which comes with age and allows the body to be overwhelmed by an attack which it could have survived in youth.

In discussing deaths involving different organs and systems I have omitted deaths caused by cancer. Nearly all such deaths are over 45 years of age and it is one of the biggest stumbling blocks on the road to long life. The otherwise robust digestive organs are heavily involved. Cancer of the lung is not only the commonest cancer in men but one of the main killers of our time. Cancer of the reproductive organs strike women very heavily. Death rates from cancer, both in men and women, have increased in recent years, the greater increase being in males, mainly due to the increase in lung cancer. No special site could be singled out in females. It is important to note that the death rates and incidence rates of cancer in men and women are by no means the same thing. Cancer in men tends to strike in more inaccessible organs and to be less easily and early detected while cancer strikes women chiefly in accessible organs and can be detected sooner. Cancer is an enemy of increasing importance and its grip more than counters the encouraging improvement in the death rate from infectious diseases. The defeat of diseases like diphtheria is a triumph, but it is overshadowed by the increasing menace of cancer.

To summerise I would say that man meets his death not because of any limit to the life of his individual tissues but because the human body is so complex the body's tissues cannot be perfectly and indefinitely maintained in face of the stresses of normal life. Man seems able ideally to live to about 110, but deaths occur at all ages, mostly in the 60s and 70s. In the normal healthy body changes are continually taking place especially in the cardiovascular system so that hitherto non-fatal stresses and infections become more and more menacing and the eventual failure of one or more systems causes death. The increase in medical knowledge is continuously improving man's ability to ward off infections and recover from them and succeeding generations are living longer and longer. Old people form an ever increasing proportion of the population. But the increasing pace of life brings greater danger in the malignant disturbance of cell replacement called cancer and especially in failure of the circulatory system through the decrease of resilience to stress as age increases. It is against cancer and arterio sclerosis that the battle for longer life must be concentrated.

Infant Mortality.

There were two cases of death of infants under one year. There were no still births.

Maternal Mortality.

There were no cases of maternal death in 1956.

Social Conditions.

There was some unemployment in the town during the year due to the credit restrictions imposed by the Government.

SECTION B.

General Provision of Health Services in the Area.

One new Clinic, a Breathing Exercises Clinic, was started in Chard at the beginning of the year.

Care of Mothers and Young Children.

Ante-Natal Clinic.

The ante-natal clinic was held once a month throughout the year and the Medical Officer, Dr. Elliott, attended each session for the purpose of taking blood samples for submission to the Laboratory. The samples are examined as a routine for Wasserman and Kahn tests, haemoglobin estimation and the Rhesus re-action. The examination of the blood of expectant mothers is now

a routine procedure in this area. The number who attended during the year was 107.

The Rh. Factor.

Many mothers these days say quite readily that they are Rh. negative or positive without knowing what they are talking about other than knowing it refers to a quality of their blood.

The Rh. factor is named after the Rhesus monkey used in the experiments which led to the discovery of the factor in 1940. The original work was done by Weiner in America.

It was found in World War II that many men following transfusion with blood of the correct group developed an unaccountable reaction. Levine showed that certain of these transfusion reactions were due to the Rh. factor.

The Rh. factor is a substance which 85% of persons have in their blood. This fact is most important to those remaining 15% whose blood does not contain the Rh. factor (Rh.—negative). When Rh. negative persons are given Rh. positive blood either by transfusion or through the common circulation of a mother and child during pregnancy, it may start the reaction. The person receiving the Rh. positive blood develops the anti-bodies to Rh. positive blood and as a result any subsequent transfusion or pregnancy may be attended by serious consequences. In the newborn the red blood cells breakdown and in the transfused jaundice may occur.

A baby's chances of suffering from this disorder vary considerably with the Rh. blood type of the parents and follow the Mendelian rules of inheritance. Since only a small proportion of all Rh. negative mothers are sensitised the general average of children born with this blood disorder is about 1 in 150. It is therefore a comparatively rare condition. The treatment is to transfuse the infant with compatible blood and the majority survive without any serious after effect.

When a mother is found to be Rh. negative a second sample of her blood is taken at the thirty-fourth week to see if there is a rise in the number of antibodies present, a sign that there may be trouble ahead. If it is thought likely that a transfusion will be necessary for the baby the mother is always admitted for her confinement to Musgrove Park Hospital, Taunton, where a specialized team is available. Should an unsuspected case occur on the district the nurse or general practitioner can always call on this team which act as a flying squad and will travel to any part of the County.

In addition to the Rh. test a second sample of blood taken at the same time is submitted to the haemoglobin test to detect any anaemia if it be present.

It is known that the haemoglobin or redress of the peripheral blood falls as pregnancy advances and probably true anaemia is present only if the percentage falls below 70%. However, it has been shown that if a daily supplement of iron is given the majority of women maintain a normal haemoglobin level throughout pregnancy. If this is done then they are more energetic and better able to face the rigours of their confinement and puerperium.

There is no doubt that anaemia of pregnancy can be prevented if patients will attend their antenatal clinics or see their own doctors in time so that any anaemia that develops can be efficiently treated. However, there are other factors in nutrition besides iron and a good mixed daily diet which includes eggs, milk and meat should be aimed at.

Domiciliary Midwifery.

The district nurses continued to attend expectant and nursing mothers in their homes, the private practitioner supervising the case.

Hospital Confinements.

In cases where it was considered necessary for the mothers to be admitted to hospital for their confinement, they were allocated a bed at Musgrove Park Hospital, Taunton. Transport for the admission of these cases was provided when necessary.

Infant Welfare Clinic.

These clinics were held twice per month and Dr. Elliott was present on all occasions. Details of attendance are shown in Appendix B, Table 1.

Apart from the immunisations and vaccinations she does, the doctor spends a great deal of her time allaying the mothers' fears which often have their origin in the folk lore handed down in families from mother to daughter. Such is the power of the matriarch that it may take many visits to the clinic before the doctor's advice is finally accepted without misgivings.

A strict timetable of ideas was necessary when the welfare work started, because infant mortality was so high and the first need being to save life, a life saving rigid discipline was required. Today many modifications of regime are suggested. Nevertheless a certain easy organisation is advised. The exponents of the modern doctrine of self regulation by infants often condemn the timetable in handling the baby. However, a young mother often worried and confused by a situation she has never before encountered is grateful for a

simple routine which helps her to plan the management of the baby throughout the day.

As far as is practical breast feeding is advocated. The success of a mother in breast feeding her infants will depend on three simple things. It will depend on the kind and degree of ante-natal care and tuition which the mother has received. It depends upon the psychological attitude of the mother and thirdly it depends upon the composition of the individual mother's breast milk. Advice on all three of these factors are given at the clinic and the amount of breast feeding is to a certain degree a direct gauge of the effectiveness of the clinic.

Mothers have become obsessional about their children's weight and worry themselves sick if baby is putting on what they imagine is too little and occasionally too much weight. Frequently the problem is a simple one and advice is gratefully received.

Constipation is another constantly recurring problem presented at child welfare clinics. The latin word " stipare " means to press and so far as derivation goes, constipation means the passage of compressed, that is, hard stools. It is not what it is commonly assumed to be, synonymous with infrequent defaecation, though that is often accompanied by the passage of hard motions. Constipation is the delay in passage of material through the bowel resulting in the formation of hard stools, the passage of which gives discomfort.

The passage of hard stools is not always uncomfortable. There may be a great contrast between the anguish on the face of the mother as she hears the marbles rattle into the pot and the baby's smile of satisfaction.

Constipation has been considered harmful but today its ill effects are thought to be only the discomfort of defaecation. No longer is alimentary intoxication believed to be the result from constipation. Yet as a nation we are so pre-occupied about our regular bowel actions that we spend £70 million a year on purgative pills, tablets and salts. The symptoms of constipation are probably largely due to fear of constipation and this is partly the result of skilful advertising. " You may be regular, but you may be a day behind " is a typical example. The fear may also be learnt from mothers who learnt from their mothers: " No stool, no school " was once a common morning threat.

Constipation often produces symptoms only because the person or parent expects it to do so. At school children are taught how their insides work and how to keep them working well. Earlier than this at the clinic, we try to ensure that, as infants, their bowel training is done without excessive anxiety on the mother's part. Good general advice on infant feeding is a good prophylactic against constipation in infancy.

The world is so full of a number of interesting things that it is a pity that people should spend an excessive amount of time, money and interest on how and what they are excreting.

Health Visiting.

The district nurses carry out general health visiting duties and Mrs. Pitt is the tuberculosis health visitor.

The primary function of a health visitor is to visit the home of the people and I am quite confident that at present this work is being done in a very efficient manner. This is particularly true in respect of the following up of children with defects discovered at school medical inspections. None are overlooked, and if parents co-operate they will derive a maximum benefit from this part of the Health Service.

Home Nursing.

In addition to their many other duties, the district nurses visit people's homes to carry out a very large number of duties. These may include dressing wounds, giving injections, bathing patients, and many other similar medical duties too numerous to list. A great deal of this work is concerned with the older members of the community, and we have every reason to be thankful for the kindly manner in which our nurses have been working during the past year.

Immunisation.

During the year the County Council as local health authority, in co-operation with the Borough Council, took every opportunity to stress the need for immunisation against diphtheria. Immunisations were carried out at the Infant Welfare Clinic and by general practitioners in the town. In addition I immunised a number of children at school. These were mainly booster injections. The total figure for the town was 164.

In 1956, following the success of the immunisation programmes in the United States and Scandinavia, the Government launched a campaign for immunisation against acute poliomyelitis. It was commenced as a planned field trial and as the supplies of vaccine were very limited indeed, only a small percentage of children applying were, in fact, immunised. Only

two were chosen from the Chard applicants but I hope I shall be allocated more vaccine in 1957.

Vaccination.

Fifty-one primary and three re-vaccinations were carried out in 1956. This is still not as many as I would like and I think that general practitioners might be able to help in this aspect of preventive medicine by persuading the parents of all infants to accept vaccination.

Home Help Service.

The Home Help Service, organised by the County Council, was available in the town throughout the year. It is of very great value and the County Council are spending more each year on this Service.

School Medical Service.

All maintained schools in the town have been inspected by me during the year and details of these inspections can be found in Appendix B, Table 2.

Children who have reached the age of fourteen years may do part-time employment while attending school. Such work is subject to Bye-Laws which control the hours and type of work permitted and demand that a satisfactory medical examination is carried out. In this connection I saw ten children during the year.

Breathing Exercises Clinic.

The clinic was held once a week throughout the year. The Health Visitor supervised the exercises at every clinic and explained the idea and method to the parents who attend with the children. The Medical Officer attended once a month to assess progress and to see all new cases and discharge those who had learnt how to control their breathing.

Minor Ailment Clinic.

I do not hold regular sessions at the clinic for the treatment of minor ailments, but arrange a clinic following a school medical inspection, so that any minor conditions with which I can readily deal, are speadily treated. This, I hope, relieves the pressure on general practitioners in their surgeries and enables them to deal with more serious and urgent matters.

School Dental Service.

The School Dental Surgeon who was working in the Chard area, resigned at the beginning of the year and no regular school dental inspection was carried out after he left although the County Orthodontist to make occasional visits to deal with patients already on his list.

Now more than ten years after the war and eight years after the institution of the National Health Service, there are a host of problems for dentists both as individuals and as a responsible group.

Probably the most worrying features of the problem are these:—

1. Britain is only very slowly improving the general standards of oral hygiene
2. There are too few dentists available at present, especially in the school and public dental services
3. There are too few applicants of the right type to the dental schools of Britain.

Now, as never before, people are developing a taste for good dental care.

The adult population of this country had just started to realise how poorly it looked after its own and its children's teeth when the alteration in payment scales combined with a shortage of dentists to slow down the valuable work which had started. Financial stringency in the public and private purses has rendered more refined conservative and orthodontic work a luxury which is increasingly more hard to support. Though individual dentists produce work of the highest possible standard, generally the National Health Service can only guarantee a bare service of extraction and simple conservative work. The finer and more skilled works which are the technical delight of the good dental surgeon are now under a cloud of mistrust and disapproval —from the patient because of cost and from the Dental Estimates Boards because they view such work as luxurious. In this area the need for a specialist in orthodontics is obvious. The dental practitioner can rarely afford time for work that is inevitably slow and exacting and which may only yield a poor financial reward in proportion to his labour. Yet many children need an orthodontic opinion and treatment and the nearest specialist is either at Bristol or Plymouth.

The shortage of school dentists is even more alarming. The shortage is understandable enough when it is realized that they are the poorest paid of all the profession. One can understand the way in which most newly qualified men go into practice as soon as they can, leaving the financially barren field of children's dentistry to enthusiasts who are happily undisturbed by consideration of their bank balances. Thus the majority of dentists go straight into practices where for the rest of their working lives they work hard and continuously for a good salary.

The present dental surgeon has an education which is almost as long as that of the doctor. The present world wide

shortage of dentists leads one to ask whether a simpler form of training, such as the New Zealand dental nurse scheme would not produce a larger number of adequately equipped people to cope with routine work. I think it would be a justifiable step to introduce some modified course of training so that dental auxiliaries can come into being in order to ease the dental surgeon's burden of routine and less skilled work. Such people could help in the provision of an efficient school service provided they worked under the supervision of fully trained dentists.

At present, due to the shortage, the most severely hampered is the school service and a practical way of overcoming the difficulty could be a scheme similar to that whereby hospitals ensure an adequate supply of house officers. A case can be made on grounds of educational desirability and practical expediency for the institution of a pre-registration year for the dentist. He could spend his year either in hospital appointments or in the school dental service.

The General Dental Council is concerned at the poor numbers and quality of the candidates at dental schools. It is certain that maintenance of high professional standards will only be possible if they make it clear that no reduction in professional status can be contemplated. Recruits of the type who are wanted in the profession will not be tempted to join if they see any relaxation of the standards or loss of prestige. The dental surgeon must continue to take his place beside the doctor as a man having a broad medical education as well as the necessary technical skill. If, however, some of the routine work can be passed by the dentist to a new type of technician, I feel that the profession would gain as a whole.

Orthopaedic Service.

An orthopaedic clinic was held every month throughout the year in Chard and was extremely well supported by the parents who appreciate not having to travel to Taunton as used to be the case. A fully qualified Orthopaedic Sister is in attendance and she sees all cases at regular intervals between their appointments with the specialist. In this way she is able to keep a constant check on progress and refer back any who should see the specialist sooner than was originally anticipated.

Ophthalmic Services.

At each school medical inspection I examine every child who has any eye defect whatsoever. I check the correction of their glasses and also check up on whether or not they are carrying out the directions issued by the Ophthalmic specialist at the last appointment. If glasses are in need of repair or the correction does not satisfy me, I refer the child to the County Oculist who holds a weekly clinic, especially for schoolchildren, at Taunton.

Whenever I visit a private school, I am struck by the few children who wear glasses as compared with the numbers in a comparable County school. This is not because there is a significant difference between the standard of vision in the two types of school. It is because in the County Schools regular routine medical inspection is carried out and the defects noticed at an early age. Undoubtedly many visual and, indeed, other defects remain undetected in schools where the children do not have the benefit of regular medical inspection.

Epileptics.

Any cases of epilepsy occurring in the area are referred to a Specialist at Taunton who is able to carry out electro-encephalogram and other necessary investigations and then advise on the correct course of treatment. A copy of his report is always available to the School Medical Officer if the patient is of school age.

Where it is considered necessary for a schoolchild to attend a special school on account of the disease, it is possible to have them admitted to the Chalfont Colony, where the Somerset County Council maintain a certain number of students.

Spastics.

During the last few years there has been realization by the public that there should be greater provision for the education and treatment of spastic children. The term is frequently used but few know its significance.

What is a spastic? Most children learn to eat, walk, talk, sit and stand without trouble. Such acts become easy to them because their muscles work together and they have control of them. A child with cerebral palsy (brain palsy) does not have control of all his muscles. As a result he often finds it difficult to do the simple acts of life. He may reach for a cup or pencil; as his hand moves it may miss the mark: he may knock over the cup or drop the pencil.

Another child with cerebral palsy may not be able to walk straight. He seems to get off balance; he may stagger, reel and weave about.

Another child may have trouble with his throat and tongue. If he tries to talk the sounds are often grunts and noises. The muscles of his face may twist and work. Seeing a child making faces and

hearing the sounds he makes give some people a wrong idea. They connect such acts with being feeble minded because some feeble minded children act that way. This may be far from the truth. Some of them are very bright. Some, it is true, are feeble minded but it is not possible to tell just by the way children with cerebral palsy look or act. Mentally the large number of them are about like other children.

The cause is sometimes due to brain damage while the baby is being born. This may be when the mother has a hard and long labour but it is not necessarily the case. It may happen with an easy birth.

Sometimes cerebral palsy may happen after birth and it has followed whooping cough, measles and meningitis.

A large number of spastic children do improve, others do not improve so much, still others not at all. Due to severe mental or physical disability some may have to be cared for in an institution for years.

It is important that all children with cerebral palsy should be under medical care and have opportunities for suitable education just as any other child.

Blind Persons.

There was one case of cataract registered during the year. One case of ophthalmia neonatorum was notified.

Ambulance Service.

The Somerset County Ambulance Service covers the area during the week days and the service worked quite smoothly throughout the year. During non-working hours and at week-ends the St. John Ambulance Brigade continued to give an amblance service to Chard and district. They are under the direction of Divisional Superintendent Brooks. Appendix B, Table 3 gives full details of work done.

National Assistance Act.

No statutory action was necessary during the year, although old people frequently show a natural reluctance to leave their house, however dismal, and regardless of their ability to look after themselves.

SECTION C.

Prevention and Control Over Infectious and Other Diseases.

A summary of notifications will be found in Appendix C, Table 1. It will be seen that there was little infectious disease in the town during 1956.

Mass Radiography.

A boy in the Secondary Modern School was found to have tuberculosis in June and arrangements were made to survey the whole school. This was carried out early in July and full details of the visit are shown in Appendix C, Table 2. Of the 385 X-Rayed, 2 were significant and one required further investigation. However, no case of active tuberculosis was found.

Later the Unit came to carry out the normal survey of the town and details of this visit are shown in Appendix C, Table 3. One case of active tuberculosis and two inactive cases were discovered. In addition seven non-tuberculous abnormalities came to light. It will be noted that 1,429 miniature films were taken and this is only 26% of the town's population and is not a good response.

Food Poisoning.

A small outbreak of food poisoning occurred among children mainly at the Chard Junior School on Friday, 13th July. It was typical of the sort of small outbreak which occurs from time to time and I think worth reporting in some detail.

About 4.40 p.m. on Friday, 13th July, I was informed by the Headmaster that several children were sick and I proceeded immediately to the school.

The symptoms were those of pallor with some pyrexia, nausea and, in some cases, vomiting. Three children were prostrated by the attack of vomiting. The illness was confined to children who had taken their mid-day meal in the school.

The first case of vomiting commenced at about 3.30 p.m. and within the next half-hour five or six other children had become ill. Specimens of vomit were obtained for examination.

The school meal consisted of pastry on which was placed sardines and sliced tomato, together with boiled potatoes, followed by milk pudding. It was prepared at the Chard Central Kitchen and delivered in containers at the school in the late morning of the day on which the meal was served.

Investigation at the kitchen showed that two brands of sardines had been used, 100 tins of A brand and 12 tins of B brand, the latter being 27½ oz. tins. Specimens of both brands of opened tins and one unopened tin of the B brand were forwarded to the laboratory. Subsequent investigation showed that the A brand sardines were quite satisfactory but the B brand sardines were contaminated. Two kinds of organisms were found in the unopened tin, neither being known pathogens. However, the two specimens of vomit

contained Staph. aureaus and these were identical. One faecal specimen examined at the same time grew no pathogens. Medical practitioners in Chard were informed on the Friday night of the outbreak and probable cause.

The total number of dinners served on 13th July by the kitchen was 1,339. Of these 80 received tinned meat and the remainder sardines. One hundred small tins of A brand were used and 12 of the B brand. Allowing two fish per child, approximately 300 children were at risk and of these 41 were known to have been ill and possibly others were ill without having reported any ill effect.

The B brand sardines were purchased from a Taunton firm by County contract and the consignment note to the kitchen was dated 6.6.55 but the date of crating in Portugal was February, 1952. Details of the packer's name and distributor's were forwarded to the County Council on 16th July.

I continued the investigation at the kitchen on 16th July. Unfortunately the supervisor who had been working at the kitchen until the previous Friday had gone away and the normal one had returned from sick leave. I was therefore unable to question the person in charge at the time of the outbreak. I inspected every worker who in any way had come into contact with the food. These included all the female staff and two men who had opened the tins. None had any history of intestinal upset, none had any Staph. infection of exposed parts and none had any throat infection. Several noticed while the Friday meal was being prepared that some of the fish from the big tins were not very fresh. One stated the fish was soft and had a slight odour. The chief cook remarked the fact to the supervisor that she did not like the smell of some of the fish but no action was taken. It is very easy to be wise after the event and I have no way of checking whether, in fact, the supervisor did receive such information although the cook's statement is verified by two assistants. If, in fact, the supervisor did receive such information, I think she made a serious error of judgment in serving this fish. Incidentally, the menu for the week showed that another type of meal with fresh fish was due to be served and I do not know why an alteration was made at the last minute.

I understand from the laboratory that further tins of this B brand were found at the Albert Street Central Kitchen, Bridgwater, and a sample batch of 12 tins were examined. Two gave a growth of Staph. aureus, one tin being very heavily infected. A tin which had been submitted to the County Analyst in case metal had been released from the tin itself by bacterial action, was reported on by Mr. Illing on 20th July. The inner surface of the tin showed no signs of corrosion and the sardines contained only traces of metallic contamination and no injurious substance was found.

It would appear that the cause of the outbreak was Staph. aureus from the sardines originating from Portugal and that the infection was probably introduced into the fish during packing. It is possible for organisms of this type to remain in a condition of suspended animation for a considerable time and commence to increase when air is allowed to enter the tins. It is interesting to note in this case that the tins were opened and the fish remained in them for about three hours before they were placed on the pastry. Then, of course, there was another period of some hours before they were actually consumed by the children in school.

It is, of course, realised that tinned fish is seldom used in school kitchens but it would be interesting to know why it was substituted for fresh fish on that day as enquiry shows that there was no shortage of supply of fresh fish in Chard on 13th July.

SECTION D.

Environmental Health Services

A. Sanitary Circumstances.

Climatic Conditions.

A total of 24.29 inches of rainfall was recorded in 1956. A very dry spring was followed by a wet and disappointing summer. The winter was not severe.

Water Supply.

The water supply was quite satisfactory in quality but a shortage was experienced from June to December. The yield from the new borehole was 40,000 gallons per day. Details of the chemical and bacteriological reports will be found in Appendix D, Table 1, together with other relevant detail concerning the distribution of the supply. All piped water in Chard is chlorinated before distribution and it will be noted that all the samples taken for bacteriological examination were satisfactory.

Drainage and Sewage Disposal.

The town's sewage disposal works continued to be most satisfactory and the

effluent was of a very high standard throughout the year. No extensions were made. It is now estimated that the provision of sewerage for the Holbear district will cost about £7,500.

Rodent Destruction.

The Rodent Operator continued to carry out routine inspections and treatments where necessary in the Town. No heavy infestations were detected.

Camping Sites.

There are two licensed sites in the town where the maximum number of caravans allowed is ten per acre. The estimated number of campers resident during the year was twenty-four caravans. In order to ensure that permanent residents were living in conditions which were not detrimental to their health, the Council have laid down strict rules concerning sites. These demand that the type of caravan used shall be of the "all-weather" variety and incorporate proper cooking and heating apparatus and also be properly insulated. They also demand adequate sanitary arrangements and a satisfactory method of refuse disposal.

Swimming Bath.

There is one privately owned swimming bath in the town where purification is by hand chlorination. Samples of the water are submitted for examination from time to time.

B. Factories Act.

Details will be found in Appendix D, Table 2.

There is still no information about the formation of an industrial medical service.

C. Housing.

Appendix D, Table 3 gives a very detailed survey of the present position of housing in the town.

The Survey Sub-Committee of the Public Health Committee continued their regular inspections and action was taken in respect of two areas for slum clearance.

D. Inspection and Supervision of Food.

Milk.

There are three registered distributors and two registered dairy premises in the Borough. Milk sampling is carried out by County Council staff.

Ice Cream.

There is one manufacturer and twenty-one premises from which pre-packed ice cream is distributed. Eighteen samples were examined in 1956, ten falling in Grade 1 and eight in Grade 2.

Meat.

There are two licensed slaughter houses in the town and Appendix D, Table 4 gives a very detailed account of the number of carcases inspected.

Clean Food Campaign.

In 1956 the Public Health Committee concentrated their efforts on the improvement of the hygiene of all food premises in the town. In order to ensure that the same standard of hygiene obtained in Chard as in the neighbouring districts we sent representatives to a combined meeting in which the new Food Hygiene Regulations were discussed. As a result the Public Health Officers of all districts in this part of Somerset interpret the Regulations in the same way and thus avoid anomalies. The Council also sent a precis of the Regulations to every food trader in Chard so that there should be no possibility of their being unaware of their obligations. Routine inspection of all food premises was proceeding at the end of the year.

APPENDIX A—TABLE 1

Registrar General's estimate of population mid 1956	5,390
Area	1,030 acres
Number of inhabited houses at the end of 1956 according to the Rate Book	1,761
Rateable Value	£63,355
Sum represented by a penny rate	£124

APPENDIX A—TABLE 2

BIRTH RATE: Comparability Factor 1.00.

		M	F
Live Births:	Total	42	36
	Legitimate	39	31
	Illegitimate	3	5
Still Births:	Total	—	—
	Legitimate	—	—
	Illegitimate	—	—
Deaths of Infants under 1 year:	Total	—	2
	Legitimate	—	2
	Illegitimate	—	—
Deaths of Infants under 4 weeks:	Total	—	—
	Legitimate	—	—
	Illegitimate	—	—

APPENDIX A—TABLE 3

DEATH RATE: Comparability Factor 0.91.

Table of Deaths	Total	M	F
Causes of Death:	59	27	32
Heart:			
Coronary Disease	5	2	3
Other heart disease	15	7	8
Circulation:			
Vascular lesions of nervous system	7	3	4
Other circulatory disease	4	—	4
Cancer of:			
Stomach	1	1	—
Lungs	2	1	1
Other Sites	3	2	1
Lungs:			
Pneumonia	3	1	2
Bronchitis	2	1	1
Leukaemia	1	1	—
Gastritis	1	—	1
Nephritis	1	—	1
Other ill-defined diseases	10	5	5
Motor vehicle accidents	1	1	—
Accidents (other than motor vehicle)	3	2	1

APPENDIX B—TABLE 1

CHARD CHILD WELFARE CENTRE

Statistics for the twelve months ended 31st December, 1956.

1. Number of children who first attended during the year and who at their first attendance were:—
   UNDER ONE YEAR OF AGE 74
2. Number of children who attended during the year and who were born in:—
   (a) 1956 56
   (b) 1955 48
   (c) 1954-51 68
3. Total attendances during the year made by children who at the date of attendance were:—
   (a) UNDER ONE YEAR OF AGE 559
   (b) OVER ONE BUT UNDER TWO YEARS OF AGE 180
   (c) OVER TWO BUT UNDER FIVE YEARS OF AGE ... 148
4. Number of individual mothers who attended during the year ... 138
5. (a) TOTAL NUMBER OF SESSIONS HELD:—
   (i) With Medical Officer 23
   (ii) Other Sessions 1
   (b) NUMBER OF CHILDREN EXAMINED BY DOCTOR ... 114
   (c) TOTAL NUMBER OF MEDICAL CONSULTATIONS 281

APPENDIX B—TABLE 2.

Name of School	No. on Roll	No. Inspected	Date of Inspection	Children having Milk	Children having Dinners	No. Immunised
Chard Infants	162	98	25/26/27.1.56	96.29%	62.36%	136
Chard Junior	328	145	20/21/22.3.56	74.69%	54.88%	28
Chard Secondary	385	104	27/28.6.56	51.95%	27.27%	—
Modern	439	120	6/7.11.56	39.84%	29.81%	—

APPENDIX C—TABLE 1

Infectious and Other Notifiable Diseases.

Whooping Cough	7
Measles	10
Ophthalmia Neonatorum	1
Scarlet Fever	2
Erysipelas	1

Analysis of Cases Notified.

	Under 1yr.	1-2	2-3	3-4	4-5	5-10	10-15	15-20	20-35	35-45	45-65	65+
Measles			2		6	2						
Whooping Cough				3	2	2						
Ophthalmia Neonatorum												
Scarlet Fever				1	1							
Erysipelas											1	

Tuberculosis

Age Group	New Cases				Deaths			
	Respiratory		Non-respiratory		Respiratory		Non-respiratory	
	M	F	M	F	M	F	M	F
-1 ...								
1-5 ...			1					
5-15 ...								
15-25 ...	2	1						
25-35 ...		1						
35-45 ...								
45-55 ...		1						
55-65 ...								
65+ ...								
Total...	2	3	1					

APPENDIX C—TABLE 2

Mass Radiography

Report of Survey at Holyrood Secondary Modern School, Chard.
3rd—5th July, 1956.

		Male	Female	Total
Miniature films	Total	216	169	385
Large Films	Total Recalled	1	4	5
	Did not attend	—	—	—
	Normal	—	2	2
	Significant	1	1	2
	Being investigated ...	—	1	1

Analysis of Tuberculous Cases.

	M	F	Total
Active Tuberculosis. Under 15 years.....	—	—	—
Under Observation. Under 15 years	1	—	1
Inactive Tuberculosis. Under 15 years ...	—	1	1
Total No. of Scholars X-Rayed...	204	162	366
Total No. of Staff X-Rayed	12	7	19

Report of Survey at The Health Centre, Chard.
12th—19th October, 1956.

Miniature Films		830	599	1429
Large Films				
	Total Recalled	19	12	31
	Did not attend	—	—	—
	Normal	7	8	15
	Significant	9	3	12
	Being investigated ...	3	1	4

Analysis of Tuberculous Cases.

	Under 15	15-24	25-34	35-44	45-59	60+	Total
Active Tuberculosis							
Male		1					1
Female							—
Total		1					1
Under Observation							
Male			1		1		2
Female							
Total			1		1		2
Inactive Tuberculosis							
Male			1				1
Female				1			1
Total			1	1			2

APPENDIX D—TABLE 1

Water Supply

Piped Supplies—results of samples taken for analysis:

Raw Water				Treated after going into supply			
Bacteriological		Chemical		Bacteriological		Chemical	
Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory
2	1	3	—	24	—	—	—

Water Supplies from public mains:

Direct to Houses		By means of Standpipes	
No. of Dwellinghouses	Population	No. of Dwellinghouses	Population
1,769	5,357	14	45

APPENDIX D—TABLE 2.

Factories Act, 1937

Inspections for the purpose of provisions as to Health
(Including Inspections made by the Public Health Officer)

Premises	No. on Register	Inspections	Written Notices	Occupiers Prosecuted
(i) Factories in which Sections 1, 2, 3, 4 & 6 are to be enforced by Local Authorities	39	19	5	—
(ii) Factories not included in (i) in which Section 7 is enforced by the Local Authority	26	11	2	—
TOTALS	65	30	7	—

Cases in which defects were found 5

Cases in which defects found were remedied 5

Outworkers.

No. of outworkers in August List required by Section 10 89

APPENDIX D—TABLE 3

Housing.

Total Number of permanent dwellings in District	1,773
Total number of permanent dwellings owned by Local Authority	853

	1955	1956
Estimated number of houses unfit for human habitation (As per Ministry Circular 55/54)	28	28
Action taken during year:—		
1. Number of houses in Clearance Areas for which		
(a) Clearance Orders have been made	5	8
(b) Compulsory Purchase Orders made	—	—
(c) Purchased by agreement	—	—
Totals	33	36
2. No. of houses included in Clearance Areas still to be made	81	
3. No. of houses in Clearance Area which have been patched for temporary accommodation under Section 2 of the Housing Repairs and Rents Act, 1954	2	
4. No. of houses demolished under Section 25 of the Housing Act, 1936	4	
5. No. of houses demolished under Section II of the Housing Act, 1936	3	
6. No. of temporary dwellings (huts, etc.) demolished	—	
7. No. of houses declared unfit under Section 9 of the Housing Repairs and Rents Act, 1954	93	
8. No. of houses closed as a result of an undertaking given by the owners or following the issue of Closing Orders	—	
9. No. of unfit houses occupied under licence	13	

	Houses erected during the year		Houses in course of erection		**Gained** from conversion of large houses or buildings into flats or dwellings	**Lost** from conversion of two or more houses to one
	For Slum Clearance	For Other Purposes	For Slum Clearance	For Other Purposes		
Local Authority	—	21	—	18	—	—
Private Enterprise	—	3	—	3	—	—

Number of Post-War Houses erected from 1st April, 1945, to 31st December, 1956.

By Local Authority	By Private Enterprise	Housing Programme for 1957. For Slum Clearance	For Other Purposes
387	72	20	30

(a) No. of temporary housing units occupied—(i) Prefabs	—
(ii) Huts, etc.	—
(b) No. of houses found overcrowded	14
(c) No. of houses made fit during year	7
Houses required:—	
(i) To replace houses scheduled for demolition	81
(ii) To abate overcrowding	14
(iii) For other purposes	183
Total number of applications for Council Houses at the end of the year	211
Total number of Council Houses sold during year	Nil

Improvement Grants made under the Housing Act, 1949-54.

No. of applications and houses dealt with by Local Authority:

	Received		Approved		Rejected	
	Aps.	No. of houses.	Aps.	No. of houses.	Aps.	No. of houses.
31.7.43—31.12.55	26	26	21	21	5	5
During year	7	7	7	7	—	—

NOTE. Number of applications approved in respect of owner/occupier ... 7

Average cost per dwelling approved ... £339